ALO--WWID-WIPP-2003-0001 Final Report

Occurrence Report

Waste Isolation Pilot Plant

(Name of Facility)

Nuclear Waste Operations/Disposal

(Facility Function)

Carlsbad Field Office Westinghouse Waste Isolation Div.

(Laboratory, Site, or Organization)

Name: xxxxx
Title: Facility Manager Designee **Telephone No.:** (505) 234-xxxx

(Facility Manager/Designee)

Name: xxxxx
Title: **Telephone No.:** (505) 234-xxxx

(Originator/Transmitter)

Name: **Date:**

(Authorized Classifier (AC))

1. Occurrence Report Number: ALO--WWID-WIPP-2003-0001

NEAR MISS TO PERSONNEL INJURY

2. Report Type and Date: Final

	Date	Time
Notification:	03/07/2003	13:11 (MTZ)
Initial Update:	03/13/2003	10:50 (MTZ)
Latest Update:	03/13/2003	10:50 (MTZ)
Final:	04/01/2003	13:29 (MTZ)

3. Occurrence Category: Off-Normal

4. Number of Occurrences: 1 **Original OR:**

5. Division or Project: WTS/WIPP

6. Secretarial Office: EM - Environmental Management

7. System, Bldg., or Equipment: PORTAPOWER UNIT

8. UCNI?: No

9. Plant Area: UNDERGROUND

10. Date and Time Discovered: 03/07/2003 10:00 (MTZ)

11. Date and Time Categorized: 03/07/2003 11:30 (MTZ)

12. DOE Notification:

13. Other Notifications:

Date	Time	Person Notified	Organization
03/07/2003	10:45 (MTZ)	DOE-FR	CBFO

14. Subject or Title of Occurrence:

NEAR MISS TO PERSONNEL INJURY

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15. Nature of Occurrence:

10) Cross-Category Items

B. Near Miss Occurrences

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16. Description of Occurrence:

An employee in the underground maintenance shop was using a portapower unit (portable hydraulic jack device) in an attempt to straighten some bent metal in preparation for removing a retaining pin on a piece of mining equipment. A portapower kit contains a threaded extension rod. This rod can be screwed into the jack piston, effectively extending its length.

The employee placed the extension rod on the end of the piston, but apparently did not engage the threads. He then operated the jack handle to apply pressure as desired. When a significant amount of pressure had been applied, the extension rod slipped off the end of the piston and struck the employee on the chest and shoulder.

The employee was escorted to the surface nurse's station for evaluation. While the extent of injury appears to be limited to some bruising, he was transported to the Doctor's office in town for further evaluation.

Pending further investigation to gather all the pertinent facts and rule out equipment failure, the event appears to be the result of an unsafe act by the employee.

UPDATE AND CLARIFICATION CONCURRENT WITH FINAL REPORT:

The information submitted in this section with the notification report has technical inaccuracies relative

to the configuration of the Portapower unit. Following is a more accurate description of the equipment configuration: Some Portapower kits have male threads on the power cylinder, an extension with male threads on one end, and a coupling with female threads to facilitate attaching the extension to the cylinder to extend the unit's working range. In this case, an older power cylinder without threads was used. As there was no way to thread the power cylinder and extension into a rigid structure, the employee aligned the two units and depended on pressure and friction to maintain that alignment. Using the portapower and extension in this configuration caused them to be less stable and more likely to dislodge.

Digital photos and a simple line drawing are available via e-mail by contacting the FMD at xxxxx.

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17. Operating Conditions of Facility at Time of Occurrence:

Does not apply.

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18. Activity Category:

02 - Maintenance

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19. Immediate Actions Taken and Results:

Employee was escorted to the surface for a medical evaluation by the nurse. As a precautionary measure, the employee was then taken to town for further evaluation by a doctor.

Work involving use of portapowers was immediately stopped and will not resume until the event is investigated further and assurance is obtained that applicable employees understand the safe use of portapower units.

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20. Direct Cause:

3) Personnel Error

A. Inattention to Detail

21. Contributing Cause(s):

4) Design Problem

C. Error in Equipment or Material Selection

22. Root Cause:

3) Personnel Error

D. Other Human Error

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23. Description of Cause:

Having selected equipment components which were not compatible with each other, the employee failed to observe and appreciate the implication of having one part with threads and the other part without. Coupled with his perceived need to expedite the work, he made errors in judgement which culminated in the sudden release of system energy and personal injury.

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24. Evaluation (by Facility Manager/Designee):

After a thorough review of the facility's Job Hazard Analysis program, employee training, and safety awareness programs, this event is attributed to poor decisions by the employee. The event has been reviewed with all other employees who may have occasion to use similar equipment.

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25. Is Further Evaluation Required?: No

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26. Corrective Actions

(* = Date added/revised since final report was approved.)

1. Conduct a safety meeting with the affected crew to review the event and stress that safety always comes before production.

Target Completion Date: 03/07/2003	**Completion Date:** 03/07/2003

2. Conduct a safety meeting to review this event with all work groups that use similar equipment.

Target Completion Date: 03/10/2003	**Completion Date:** 03/10/2003

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27. Impact on Environment, Safety and Health:

While the impact on employee health appears minimal at this time, the event had high potential to cause serious injury.

The employee returned to work on his next scheduled shift.

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28. Programmatic Impact:

none

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29. Impact on Codes and Standards:

none

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30. Lessons Learned:

Stop. Think. Evaluate. There is never a reason to place production ahead of safety. Even the most reliable, competant employee can take a shortcut if he feels subtle pressure to get the job done quickly.

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31. Similar Occurrence Report Numbers:

1. none identified

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32. User-defined Field #1:

33. User-defined Field #2:

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34. DOE Facility Representative Input:

The Carlsbad Field Office-WIPP Facility Representative (FR) concurs that immediate actions taken were reasonable and timely. The WIPP FR attended the safety meeting conducted with the affected crew on 03/07/03 to further emphasize that supervisors and workers review and implement principles of safe job performance as described in the facility's job hazard analysis program. The WIPP Site's Lessons Learned Committee, of which the FR is a member, published and distributed a lessons-learned bulletin describing this event and the steps necessary to preclude its recurrence.

Entered by: xxxxx Date: 04/01/2003

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35. DOE Program Manager Input:

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36. Approvals:

Approved by: xxxxx, Facility Manager/Designee
Date: 03/13/2003
Telephone No.: (505) 234-xxxx

Approved by: xxxxx, Facility Representative/Designee
Date: 04/01/2003
Telephone No.: (505) 234-xxxx

Approved by: Approval delegated to FR
Date: 04/01/2003
Telephone No.:
